



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235-1720

Respondent Name

DALLAS NATIONAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-12-2105-01

MFDR Date Received

February 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fee should be paid in accordance with DWC Rule 134.403. Hospital Facility Fee Guideline – Outpatient. . . . We submitted request for reconsideration requesting outlier payment in accordance with the above rule as well as Medicare Processing Manual, Section 10.7. Box 80 of UB-04 indicates that provider has requested 130% of OPPS and separate reimbursement for implants, as well as outlier payment."

Amount in Dispute: \$2,012.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent asserts the amount of reimbursement is commensurate for the services described and provided as they are found under the Workers Compensation State Fee Guideline as well as the other guidelines listed above. The amount reimbursed was proper according to the submission of the Requestor."

Response Submitted by: Lewis & Backhaus, PC, 5501 LBJ Freeway, Suite 800, Dallas, Texas 75254

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 31, 2011	Outpatient Hospital Services	\$2,012.98	\$2,012.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - P303 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business
 - U899 – Procedure has exceeded the maximum allowed units of service
 - XE27 – This is a packaged service based on Medicare guidelines as defined in the CMS-Publication 60A, which states: Packaged Revenue Codes The following revenue codes when billed under OPPOS without HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services are: 0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, 0275, 0276, 0278, 0279, 0280, 0289, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0637, 0700, 0709, 0710, 0719, 0720, 0721, 0762, 0810, 0819 and 0942. Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCS code in order to assure payment under OPPOS. Return to provider (RTP), claims which contain revenue codes that require a HCPCS code when no HCPCS code is shown on the line. No separate payment allowed
 - Z652 – Recommendation of payment has been based on this procedure code, 27810, which best describes services rendered. Recommendation of payment has been based on this procedure code, 76000, which best describes services rendered. Recommendation of payment has been based on this procedure code, 84703, which best describes services rendered.
 - Z710 – The charge for this procedure exceeds the fee schedule allowance.
 - W1 – Workers Compensation State Fee Schedule Adjustment.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Are the number of units for procedure code 27810 supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. What is the additional recommended payment for the implantable items in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced/denied payment for disputed services with reason codes 45 – “Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement” and P303 – “This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.” Per Labor Code §413.011(d-6) the provisions that authorized insurance carriers to contract with health care providers for fees that are different from those specified by the Division’s fee guidelines expired on January 1, 2011. No information was found to support that the services in dispute are subject to a contractual agreement related to a workers’ compensation health care network that had been certified under Insurance Code Chapter 1305. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The insurance carrier reduced or denied additional units of procedure code 27810 with reason code U899 – “Procedure has exceeded the maximum allowed units of service.” Review of the submitted medical bill finds that the provider billed this service with 3 units. Review of the submitted medical documentation finds that only 1 unit is supported. The insurance carrier’s denial reason is supported with regards to the 2 additional units of procedure code 27810; therefore, only 1 unit of procedure code 27810 will be considered for reimbursement.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate

reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are \$2,460. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 84703 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.57. 125% of this amount is \$13.21. The recommended payment is \$13.21.
 - Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 27810 billed on the same claim. The use of a modifier is not appropriate. Separate reimbursement is not recommended.
 - Procedure code 27810 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0129, which, per OPPS Addendum A, has a payment rate of \$108.73. This amount multiplied by 60% yields an unadjusted labor-related amount of \$65.24. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$63.39. The non-labor related portion is 40% of the APC rate or \$43.49. The sum of the labor and non-labor related amounts is \$106.88. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.206. This ratio multiplied by the billed charge of \$5,600.00 yields a cost of \$1,153.60. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$106.88 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$1,701.66. The allocated portion of packaged costs is \$1,701.66. This amount added to the service cost yields a total cost of \$2,855.26. The cost of this service exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$2,668.22. 50% of this amount is \$1,334.11. The total APC payment for this service, including outlier payment, is \$1,440.99. This amount multiplied by 200% yields a MAR of \$2,881.98.
5. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
 - "IMP SYN GUIDEWR 1.25MM THRD" as identified in the itemized statement and labeled on the invoice as "1.25MM THREADED GUIDE WIRE 150MM" with a cost per unit of \$34.00 at 2 units, for a total cost of \$68.00;
 - "IMP SYN 4.0 CANN SCR LT 42MM" as identified in the itemized statement and labeled on the invoice as "4.0 CANNULATED SCREW LONG THREAD/42MM" with a cost per unit of \$227.00 at 2 units, for a total cost of \$454.00.

The total net invoice amount (exclusive of rebates and discounts) is \$522.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$52.20. The total recommended reimbursement amount for the implantable items is \$574.20.

6. The total allowable reimbursement for the services in dispute is \$3,469.39. The amount previously paid by the insurance carrier is \$391.11. The requestor is seeking additional reimbursement in the amount of \$2,012.98. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,012.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$2,012.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	November 12, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.